RETURN TO: CITY OF COUNCIL BLUFFS, IOWA
ATTN: CITY LEGAL DEPARTMENT
OR CITY CLERK
209 PEARL STREET
COUNCL BLUFFS, IA 51503

CITY CLAIM NO. _____

NOTICE OF CLAIM/LOSS

NAME OF CLAIMANT: _____ DAY PHONE: _____

ADDRESS: _____DOB: _____ SS#_____

DATE & TIME OF LOSS/ACCIDENT: _____

LOCATION OF LOSS/ACCIDENT: _____

DESCRIPTION OF LOSS/ACCIDENT: _____

_____

_____

_____(USE BACK OF FORM, IF NECESSARY)

TOTAL DAMAGES CLAIMED: $_____

WITNESS(ES) (Name(s), Address(es), Phone No(s).)_____

_____

_____

WAS POLICE REPORT FILED _____ YES _____ NO

IF MEDICAL ATTENTION WAS REQUIRED, PLEASE PROVIDE NAME, ADDRESS, AND TELEPHONE NO. OF TREATING PHYSICIAN AND FACILITY:

_____

_____

_____

HAVE YOU RESUMED NORMAL ACTIVITIES? _____ YES _____ NO

IF YOU INCURRED PROPERTY DAMAGE, PLEASE DESCRIBE AND PROVIDE COPIES OF PHOTOGRAPHS, ESTIMATES, INVOICES, AND ANY

OTHER RELEVANT INFORMATION: _____

_____

_____

LIST INSURANCE PROVIDER AND COVERAGE: _____

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT THE ABOVE INFORMATION IN SUPPORT OF MY CLAIM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

NOTE: IT IS A FRADULENT PRACTICE PUNISHABLE BY FINE OR IMPRISONMENT TO KNOWINGLY MAKE A FALSE CLAIM (SECTION 714.8(3), CODE OF IOWA)

_____ _____

DATE CLAIMANT'S SIGNATURE